

**BOURNEMOUTH & POOLE SAFEGUARDING ADULTS
BOARD**

EXECUTIVE SUMMARY

Regarding the Serious Case Review

In respect of Miss A

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Date: 13 May 2010
Updated: 1st October 2010

Miss A: Died: 07.01.08 aged 36

**1. Introduction
Reason for Serious Case Review**

- 1.1 Miss A had a severe learning disability, limited communication skills and epilepsy controlled with medication. She had lived with her mother Mrs A. Miss A. had had monthly respite care in 3 respite health settings initially, and from 2005, 3 respective Social Care commissioned settings. She died in the last setting in January 2008 when Mrs A was aged 71 years. Miss A had been known to get up at night, and in the Dorset Health Care settings there were waking night staff and, in the first of the Social Care settings, an alarm.
- 1.2. In September 2007, Mrs A had to have an operation and requested Social Care to commission a period of respite during this time. The previous 2 Social Care commissioned settings were not available, and respite was booked at Residential Setting 3(RS3), a residential establishment for 8 residents who have learning disabilities, from 9th October 2007.
- 1.3 Following Mrs A's operation, it was no longer possible for Miss A to return home. Borough of Poole Adult Social Care agreed that Miss A. could stay at RS3 while a long-term supported living placement was found. Mrs A wanted Miss A to remain at RS3.
- 1.4 Miss A was reported missing at 07.15 on the morning of 7th January 2008. She was found dead in the neighbour's alleyway at about 08.40 am by the neighbour's cleaner. The subsequent post-mortem concluded that she died from internal injuries following a fall from a height. In his report, the coroner concluded that she probably exited from a first floor window, but no evidence could be found of which window, means or motive. He recorded an open verdict.
- 1.5. The following agencies were involved in Miss A's care:-
- Borough of Poole Children's Social Care from 1982 to about 1990.
 - Borough of Poole Adult Social Care from about 1990 to January 2008.
 - GP from 1972 to 2008.
 - Dorset Healthcare Trust Miss A from 1982 to 2006.
 - RS3 Miss A from September 2007 to January 2008.
 - Care Quality Commission with RS3 from January 2007 to January 2008.
- 1.6. A formal decision to conduct a Serious Case Review (SCR) was made by the Serious Case Review Panel of Dorset Adult Protection Committee on 25.06.09. The uncertainty of how Miss A. had died led to the view that an

examination of interagency work prior to this was needed in order to determine whether this could have been improved and preventative action taken.

- 1.7. A review into the delay in implementing a SCR was requested by the Serious Case Review panel in December 2009 and undertaken by the Head of Adult Social Services Commissioning.
- 1.8. The SCR was conducted in accordance with the Protocol for undertaking SCRs agreed by Bournemouth & Poole Safeguarding Adults Board (BPSAB) on November 2009. It is recognised that, until that date, agencies were following the Pan Dorset Adult Protection Committee guidance on SCRs of May 2008.
- 1.9. The Serious Case Review Panel met on:-

11th December 2009
13th January 2010
8th February 2010
1st March 2010
9th April 2010
5th May 2010
4th June 2010
28th July 2010

2 The issues revolve around:

- Appropriate transfer of information between agencies and establishments.
- Continuing assessment and long-term planning, to ensure that Miss A was placed in a residential setting appropriate for her needs.
- Commissioning and review of placements to ensure that they continue to meet up-to-date assessed need.
- Risk assessment of assessed needs and the impact of residents individually and collectively on each other and their environment.

3. Conclusions

- 3.1 Miss A would not have died if she had not fallen out of an upstairs window. This would have been prevented if all the upstairs windows had had restrictors. However the windows were small, so the risk would have been difficult to anticipate. In residential care for adults, a balance has to be struck between avoidance of all risk and creating a homely environment.

3.2 Risk Assessment

- 3.2.1 Her death *might* have been prevented if staff had been alerted to her getting up in the night in time to prevent her going out of a window, or if

the assessment of need had established that she should have been in an establishment with the ability to respond quickly to her getting up at night and moving about.

- 3.2.2 The CQC report on RS3 following an unannounced visit on 13.09.07, did not require there to be window restrictors, nor does the General Service Specification for the Provision of Residential Care for Adults with a Learning Disability in Independent Sector Homes.
- 3.2.3 Standard 42 of National Minimum Standards, which guide good practice but are not enforceable, point 42.3 states “the registered manager ensures the health and safety of service users including: provision and maintenance of window restrictors based on assessment of vulnerability and risk to service users”. There was no previous specific incident which made it appear possible that a resident could exit from any of the small windows upstairs.
- 3.2.4 The sleeping in room is downstairs and at the back of the house, which would make it difficult for a sleeping member of staff to be alerted to a resident getting up.
- 3.2.5 There was plenty of evidence in the daily log of RS3 about Miss A getting up at night and, at times, going into other resident’s rooms which could have put her at risk and/or caused friction between Miss A and other residents.
- 3.2.6 Although there is evidence of Miss A getting up at night, both prior to RS3 and while she was at RS3, there does not appear to have been effective recorded communication between RS3 and Social Care Manager about this.
- 3.2.7 Risk assessments in relation to individuals were being carried out in RS3, but continued updating of risk assessments of the environment in relation to the changing needs of the residents individually and collectively should also have been undertaken.

3.3. Transfer of Information

- 3.3.1 In the assessment of need January – October 2005, it is recorded that Miss A got up in the night. The healthcare settings had waking night staff. When Miss A transferred to the first Social Care commissioned provision, the Care Manager was aware of this and considered the need for a pressure mat. This was not necessary as the first setting had an alarm system.
- 3.3.2 The next assessment of need in December 2006 said 24 hour care was needed but did not mention night wandering. The learning from the previous respite settings does not appear to have been carried forward.
- 3.3.3 It is recorded that the second social care setting informed the Practice

Supervisor in May 2007 that they were concerned about night care and would let the care manager know if in future waking night staff were needed.

- 3.3.4 It is recorded in RS3 daily logs that Miss A got up in the night on many occasions at RS3 and at times went into other people's rooms. However, this is not on record as having been shared with the Care Manager sufficiently.

3.4. Assessment and Long Term Planning

- 3.4.1 There was no evidence that an overall thorough proactive long-term assessment of Miss A's needs and how best to meet them had taken place, especially when the plans changed from respite care to long-term care. This should have taken into account the potential implications of her nocturnal wandering in the context of where she was placed and with whom she was placed.

- 3.4.2 A carer's assessment was not undertaken, which, if it had been, would have underlined the fact that Mrs A was getting older and finding it more difficult to care for Miss A, and that short-term contingency plans and long-term plans based on full assessment needed to be made.

- 3.4.3 Care Plans were completed in September 2005, October 2005 and December 2006. The two in 2005 indicated that Miss A had no concept of danger and would not understand the impact of her own behaviour on others or defend herself if threatened; and that 'she gets up several times per night and staff may need to be alerted to this'. However, the Care Plan of December 2006, which was given to RS3 prior to admission, made no reference to disturbed sleep patterns, though said that 24 hour care was required. Again, it does not appear that information from previous assessments was carried forward.

- 3.4.4 An Individual Service Design process began in December 2007 and was not concluded. It said that she 'sleeps through the night' though the RS3 Manager is said to have disputed this verbally, there is no evidence that she confirmed this in writing.

3.5. Commissioning and Review of Placements

- 3.5.1 When considering placements, the assessment of need must match the provision in terms of safe building requirements, sufficient staffing day and night, and the existing mix of residents.

- 3.5.2 Communication of existing and changing needs must take place continually and be confirmed in writing between commissioner and provider. This is the responsibility of the commissioner to review and re-assess the service user's needs and the provider to inform the

commissioner of significant changes.

- 3.5.3 There needs to be clarity over whose responsibility it is to provide equipment when a need is identified – the provider or the commissioner. Since RS3 did not normally take residents who had night time requirements, in this case it would appear to be the responsibility of the commissioner to assess the need and provide for it.

3.6. Serious case review Initiation.

- 3.6.1 The Serious Case Review Protocol was revised after this incident took place.
- 3.6.2 However there was considerable delay before it was instigated and all Managers need to be clear about the protocol and the criteria for holding a serious case review.

3.7 Summary of main areas of concern

- Sleeping in staff at RS3 did not have the means or location to alert them when Miss A was at significant risk.
- There was no evidence of up to date risk assessments of the changing needs of the environment and the residents in relation to each other at RS3.
- Although Social Care had information about Miss A getting up at night in 2005, this was not carried forward to the assessment and care plan of December 2006 and therefore RS3 were not made aware of this at the outset.
- There was no evidence that information about Miss A's continued getting up at night & wandering, including going into other people's rooms, was communicated by RS3 back to Social Care.
- No updated thorough assessment of need to inform the commissioning of a placement was undertaken by Social Care when the plan changed from respite to long term care in October 2007, although conclusions were reached about the type of placement required. The assessment was not begun until December 2007.
- A carer's assessment of Mrs A as an older carer was never undertaken by social care.

4. Recommendations from Overview Author

4.1 Risk Assessment

- 4.1.1 CQC inspections should ensure that appropriate risk assessments are completed in relation to both the environment and individuals. See Standard 42 of Minimum Standards.
- 4.1.2 Establishments must undertake regular risk assessments of the

environment which take account of the changing needs and vulnerability of their residents both individually and collectively.

- 4.1.3 Sleeping in night staff must be able to hear significant movements and needs of residents – by equipment for alerting staff and/or proximity of sleeping in rooms.
- 4.1.4 A regular and updated risk assessment must take place on the impact of residents on each other, both new and existing. Previous knowledge and changing circumstances must be included in this.

4.2 Transfer of Information Assessment and Long-Term Planning

- 4.2.1 Comprehensive assessment of need is required which takes into account previous history and knowledge, previous placements, the needs and abilities of current carers, and the short and long-term needs of the service user. This assessment of need must be reviewed and updated a minimum of annually or earlier if circumstances change significantly.
- 4.2.2 Regular management supervision must ensure this happens.
- 4.2.3 Care Plan forms must specifically reference night time needs.
- 4.2.4 A Carer's assessment must be undertaken for all carers who have needs of their own and/or whose ability to care may change. A pro-active contingency plan for care should be in place.
- 4.2.5 The changing abilities of older carers should be recognised and worked with sensitively in assessments of long term needs and plans.

4.3 Commissioning

- 4.3.1 When considering placements, the assessment of need must match the provision in terms of safe building requirements, sufficient staffing day and night, and the existing mix of residents.
- 4.3.2 Communication of existing and changing needs must take place continually and be confirmed in writing between commissioner and provider. This is the responsibility of the commissioner to review and re-assess the service user's needs and the provider to inform the commissioner of change.
- 4.3.3 There must be clarity over whose responsibility it is to provide additional equipment such as night time alarms. This should be the commissioner where assessed needs are clearly outside of the normal provision of the establishment.

4.4 Serious Case Review Initiation

4.4.1 All managers must be aware of and follow Serious Case Review Protocol and criteria.

Jan Sayers
Overview Report Author